STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185382	A. BUILDING _____ B. WING _____	02/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE AND REHABILITATION CENTER	47 MARGO AVENUE BARDWELL, KY 42023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted on 02/15/11 through 02/18/11, to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S&S of a "D". Abbreviated surveys, KY #15806 and KY #15480 were conducted in conjunction with the annual survey. KY #15806 was substantiated with deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Countryside Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157** 1. The physician for resident #1 was notified of the resident's behavior exhibited on 8/13/10, 8/18/10, 8/23/10 and 9/4/10 by Unit Manager on 3/11/11. The IM Ativan order for resident #1 was discontinued 10/27/2010.	

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Aaron Cagle — TITLE: Administrator — (X6) DATE: 3/31/11

leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to immediately inform the resident's physician of a significant change in the resident's physical, mental, or psychosocial status for one resident (#1), in the selected sample of 13. Interviews with staff revealed Resident #1 became agitated and the staff feared for the resident's safety, however, they failed to notify the physician of the residents change in status and utilized a "standing order" for Ativan (anti-anxiety) intramuscular (IM) for agitation. Findings include: A review of the facility policy entitled, "Change in Condition of a Resident," dated January of 2008, revealed it was the policy of the facility to take appropriate action and provide timely communication to the resident's physician and responsible party, related to a change in condition of a resident. The action steps included the licensed staff were to determine if there had been a change of condition for the resident. The licensed staff initiated actions to ensure the safety of the resident. The licensed staff conferred with the physician to determine what actions might be necessary to meet the immediate needs of the resident. Resident #1 was admitted to the facility on 01/05/07, with diagnoses to include Nonpsychotic	F 157	2. Current residents with behaviors were reviewed 3/1/11 and no physician notifications were indicated. The Interdisciplinary team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager reviewed current residents for prn IM psychotropic medication orders on 2/22/2011 and no other residents were identified. 3. Re-education of the Director of Nursing Services and the Assistant Director of Nursing Services was completed by the Regional Director of Clinical Operations on 2/18/11 regarding change in condition of a resident and physician notification. Re-education of licensed nurses was completed on 2/25/11 by the Director of Nursing and/or the Assistant Director of Nursing Services regarding change in condition of a resident including physician notification. The re-education	

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F 157	Continued From page 2 Mental Disorder and Anxiety Disorder. A review of the significant change minimum data set (MDS) assessment, dated 01/25/11, revealed the facility identified the resident exhibited behaviors of being verbally abusive and resisted care. A review of physician orders, dated 08/11/10, revealed an order for a one time dose of Ativan 2 milligrams (mg) IM for extreme agitation. Physician orders dated 08/11/10, revealed an order to begin Ativan 1 mg. IM every six hours as needed (prn) for extreme agitation. A review of the medication administration records (MAR), dated August and September 2010, revealed the Ativan 1 mg. IM medication was administered on 08/13/10, 08/18/10, 08/23/10 and 09/04/10, due to extreme agitation. An interview with Licensed Practical Nurse (LPN) #2, on 02/18/11 at 10:40 AM, revealed she administered Ativan 1 mg. IM to Resident #1, on 08/13/10. LPN #2 stated Resident #1 was so agitated she feared for the resident's safety and felt the resident might have a heart attack, due to the level of his/her agitation. She would have contacted the physician, due to the level of agitation, but did not do so because the standing order for the Ativan IM medication was available. An interview with the LPN #4, on 02/18/11 at 09:15 PM, revealed she administered the Ativan 1 mg. to Resident #1, on 08/23/10. LPN #4 revealed Resident #1 had behaviors at times described as, "almost in a rage." She attempted alternative interventions, which were ineffective. LPN #4 revealed the resident's behavior was "out	F 157	included assessment of resident behaviors, determining root cause of the behavior, developing a plan of care for the behaviors and reviewing the plan of care to validate the plan is effective. The physician will be notified by the licensed nurse when a new behavior occurs, there is any change in condition of the resident or when interventions to manage behaviors are not effective. 4. The Nursing Management team which includes the Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers will conduct audits weekly for 4 weeks then monthly for two months that physician notification and interventions have been implemented. Identified issues will be corrected upon discovery. The Director of Nursing Services will report results to the Performance Improvement Committee which includes the Administrator, Dietary Manager, Director of Nursing Services, Assistant Director of Nursing Services, MDS Coordinator, Unit Manager, Social Services,	

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F 157	Continued From page 3 of the normal" for the resident and she feared for the resident's safety. LPN #4 stated if she had not had the standing order for Ativan IM, she would have contacted the resident's physician for directions to care for the resident. An interview with LPN #3, on 02/18/11 at 10:50 AM, revealed she administered the Ativan 1 mg. IM to Resident #1, on 09/04/10. LPN #3 revealed the resident had been yelling and screaming much of the day. She attempted multiple alternative interventions, however, the resident remained extremely agitated and she feared the resident could possibly harm him/herself, by falling out of the bed. LPN #3 stated she would normally notify the physician of the type of behavior Resident #1 displayed, but did not do so due to the availability of the standing order for the Ativan IM. An interview with LPN #1 Unit Manager, on 02/18/11 at 10:30 AM, revealed the physician discontinued the order for Ativan IM, on 10/27/10, because a standing order for the medication made it too easy to bypass other interventions to address the resident's behavior. She stated, while there was not a policy related to standing orders for IM medications for agitation/anxiety, she felt the physician should be notified anytime a resident's behavior was so agitated IM medication was required to treat the behavior. An interview with the Director of Nursing, on 02/18/11 at 3:30 PM, revealed she did not have a problem with the standing order for Ativan IM. She stated the extreme agitation was a normal behavior for the resident at that time and she felt the licensed staff were justified in the decision to utilize the medication, without contacting the	F 157	Activities, Dietary Manager, Business Office Manager and Medical Director for further recommendations.	3-12-11

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F 157	Continued From page 4 physician regarding the resident's extreme agitation. Observations of Resident #1, on 02/15/11 at 3:00 PM, 02/16/11 at 9:10 AM and 02/16/11 at 12:00 PM, revealed the resident was either in the bed or up in a geriatric chair and was calm. An observation, on 02/16/11 at 1:30 PM, revealed the resident was in the television room, adjacent to the nurses station, yelling out periodically. Staff responded quickly to address the behavior and the resident calmed with verbal intervention.	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined the facility failed to ensure the care plan interventions were followed for one resident (#5), in the selected sample of 13, related to the use of a bed clip alarm. Findings include: A review of the facility policy titled, "Care Standards," dated January 2008 revealed, "It is the policy of the center to provide necessary care and services to assist each resident to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well being in accordance with a comprehensive assessment and plan of care."	F 282	F282 1. An assessment of resident # 5 was completed by the Interdisciplinary team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager and an under seat chair alarm was applied to the resident's wheelchair on 3/2/11 with the continued use of the bed clip alarm. Resident #5's care plan and CNA care card was updated by the Unit Manager on 3/2/11. 2. Current resident's care plans and CNA care cards were reviewed for falls interventions by the Director of Nursing Services and the Interdisciplinary team which includes the Administrator, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager by 3/2/11. Interventions in place as care planned.	

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F 282	Continued From page 5 A record review revealed Resident #5 was admitted to the facility on 04/25/07, with diagnoses to include Transient Ischemic Attack, Cerebral Vascular Disease (CVA), Hypertension, Depression, and Mental Illness, and Osteoporosis. Resident #5 sustained a fall, on 01/28/11, in the resident's bathroom and subsequently was sent to the Emergency Room for evaluation. X-ray reports revealed a mild compression fracture of the Thoracic Vertebrae T11 and T12, of undetermined age. A review of the quarterly Minimum Data Set (MDS) dated 01/06/11, revealed the facility identified Resident #5 as having modified independence with cognition and required extensive assistance of one staff member with activities of daily living. A review of a "Device Evaluation," dated 01/28/11, revealed the resident required a clip alarm while in bed as a medical necessity for safety awareness, due to non-compliance with asking for assistance. A review of the Comprehensive Care Plan, dated 02/06/11, for the problem, "Risk for falls related to history of CVA and dizziness" revealed interventions included the use of a bed alarm due to noncompliance with asking for assistance. A review of the Certified Nursing Assistant (CNA) care plan, dated 01/28/11, revealed interventions included the use of a bed and chair alarm. Observations, on 02/15/11 at 10:55 AM and at 3:10 PM, and 02/16/11 at 8:55 AM, and 02/17/11 at 1:50 PM, revealed there was no bed clip alarm utilized for Resident #5.	F 282	3. Staff re-education included placement and functioning of devices, following care plan interventions and CNA care card interventions related to falls. This was completed on 2/25/11 by the Director of Nursing Services and/or Assistant Director of Nursing Services. 4. The Unit Manager or the House Supervisor will check 10 residents care plans to ensure falls interventions and devices are in place daily for 3 weeks, then 5 days a week for 2 weeks, then monthly for 2 months. . The Director of Nursing Services will review the findings with the Performance Improvement committee which includes the Administrator, Dietary Manager, Director of Nursing Services, and Assistant Director of Nursing Services, MDS Coordinator, Unit Manager, Social Services, Activities, Dietary Manager, Business Office Manager and Medical Director for further recommendations.	3-12-11

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F 282	Continued From page 6 An interview with four CNAs (#5, #6, #7, and #8), on 02/17/11 at 1:55 PM, and 02/18/11 at 1:25 PM, at 1:30 PM, and at 3:00 PM, respectively, revealed they were aware Resident #5 required a bed clip alarm, however, they provided no explanation regarding the lack of bed clip alarm. An interview with CNA #5, on 02/17/11 at 1:55 PM, revealed she was unable to locate the resident's bed clip alarm. She stated the resident should have a clip alarm while in bed. An interview with Licensed Practical Nurse Unit Manager, on 02/18/11 at 3:05 PM, revealed she expected staff to consult the care plan to determine resident needs. She was aware the resident required a bed clip alarm. An interview with Registered Nurse #3, on 02/18/11 at 3:15 PM, revealed she expected the CNA to consult the CNA care plan to determine resident needs. She was aware the resident required a bed clip alarm. An interview with the Director of Nursing, on 02/18/11 at 3:25 PM, revealed she expected the clip alarm to be in place as directed by the physician's order and the resident's comprehensive care plan. She expected the nurse on duty to update the CNA care plan and comprehensive care plan.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two residents (#3 and #5), in a selected sample of 13. Resident #3 exited the facility without staff knowledge on 11/25/10 and Resident #5 was observed on three consecutive days without a safety alarm in place, in accordance with care plan interventions. Findings include: 1. Resident #3 was admitted to the facility, on 09/25/10, with diagnoses to include Persistent Mental Disorder, History of Traumatic Brain Injury, Muscle Weakness and Difficulty in Walking. Review of the admission Minimum Data Set (MDS) assessment, dated 10/04/10, revealed the facility assessed Resident #5 had disorganized thinking and inattention and required assistance for transfers and ambulation. Resident #3 was mobile and used a wheel chair with a self release seat belt to prevent falls and had behaviors of wandering in the wheelchair. The facility identified Resident #3 on 09/25/10, as at risk for elopement. Care plan interventions included monitoring behaviors with redirection when behaviors were present. On 11/25/11 at approximately 5:30 PM, Resident #3 exited the facility through the locked unit doors and proceeded out the doors of the front of the	F 323	F 323 1. Resident #3 was assessed by the licensed nurse with no injuries noted and re-assessed for elopement risk on 11/25/10. The care plan for resident #3 was updated on 11/25/10 by the licensed nurse. Resident #3 currently has a wander guard alarm in place due to risk for elopement. Resident #5 was re-assessed by the Interdisciplinary team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager and has a bed and chair alarm as of 3/2/11. 2. Residents were re-assessed for elopement risk and care plans revised as indicated on 11/26/10 by the Interdisciplinary team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager. Current residents were re-assessed to ensure fall interventions were in place by Interdisciplinary	

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F 323	Continued From page 8 building, without staff knowledge. At the time of the incident staff were occupied with other residents. The nurse and CNA #2 were assisting one resident, CNA #3 and #4 were assisting residents in the dining room and Certified Medication Technicon (CMT) was administering medications on the 300 Hall. A visitor assisted Resident #3 back into the building and informed CNA #3. A review of Nursing Notes, dated 11/26/10 at 1:00 PM, revealed Resident #3 had exited the facility the previous day at approximately 5:30 PM while ambulance staff were entering the building with a stretcher for transfer of another resident. Notifications were made to the family and physician at 1:30 PM and the resident was assessed by the nurse with no injury found. Fifteen minute visual checks were implemented and documented. Resident #3 was discharged to another facility on 11/27/10. An interview on 02/15/11 at 4:15 PM with CNA #5, revealed she was transporting residents from the dining room to their bedrooms and was not aware of the event until the next day, on 11/26/11. An interview on 02/15/11 at 4:25 PM with CNA #2, revealed he was assisting the nurse with another resident at the time of the event and was not aware of the incident until the next day. An interview with Licensed Practical Nurse #2 on 02/16/11 at 10:15 AM, revealed normally she would be at the Nursing Station during meals, however, on 11/25/10, "A resident was dying" and she and CNA #2 were caring for and preparing to transfer that resident to the hospital. She revealed CNA #3 came to her regarding Resident	F 323	team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Business Office Manager and Dietary Manager on 3/2/11. 3. Staff was educated on the Secure Care alarm system installed at facility on 1/20/11 by the Maintenance Director/Assistant Director of Nursing Services. Staff were re-educated on the elopement risk process, elopement risk residents, placement and functioning of devices and implementing fall interventions on 2/25/11 by Director of Nursing Services and/or Assistant Director of Nursing Services. 4. An elopement review audit, that includes residents at risk for elopement, and a fall intervention audit will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Managers weekly for 4 weeks, then monthly for 2 months. The Director of Nursing will present results to the Performance Improvement	

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F 323	Continued From page 9 #3, however, she told the CNA to, "Hold that thought", due to the fact she was providing care to the resident to be transferred. LPN #2 stated she "forgot" to ask CNA #3 what she was attempting to report regarding Resident #3 and was not aware of the incident, until the next day. An interview conducted 02/16/11 with the Director of Nursing (DON) and Administrator at 10:10 AM, revealed they expected the nurse and a CNA to monitor the exits from the nursing desk. While staff were preoccupied with other duties, Resident #3 exited the building, during the time there was increased traffic in and out the doors, prior the transfer of the ill resident. Resident #3 propelled himself out the doors without staff knowledge. Resident #3 was returned to the building within in five minutes by one of the visitors and CNA #3 was notified. The CNA attempted to notify the nurse who was attending a critically ill resident and did not make a second attempt to notify the nurse. 2. A record review revealed Resident #5 was admitted to the facility, on 04/25/07 with diagnoses to include Transient Ischemic Attack, Cerebral Vascular Disease (CVA), Hypertension, Depression, and Mental Illness, and Osteoporosis. Resident #5 sustained a fall on 01/28/11 in the resident's bathroom, and subsequently was sent to the Emergency Room for evaluation. X-ray reports revealed a mild compression fracture of the Thoracic Vertebrae T11 and T12, of undetermined age. A review of the MDS dated 01/06/11, revealed the facility identified Resident #5 as having modified independence with cognition and required extensive assistance of one staff member with	F 323	Committee which includes the Administrator, Dietary Manager, Director of Nursing Services, and Assistant Director of Nursing Services, MDS Coordinator, Unit Manager, Social Services, Activities, Dietary Manager, Business Office Manager and Medical Director for further recommendations.	3-12-11

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F 323	Continued From page 10 activities of daily living. A review of a "Device Evaluation," dated 01/28/11, revealed the resident required a clip alarm while in bed as a medical necessity for safety awareness, due to non-compliance with asking for assistance. A review of the Comprehensive Care Plan, dated 02/06/11, for the problem, "Risk for falls related to history of CVA and dizziness," revealed interventions included the use of a bed alarm, due to noncompliance with asking for assistance. Observations, on 02/15/11 at 10:55 AM and at 3:10 PM, and 02/16/11 at 8:55 AM, and 02/17/11 at 1:50 PM, revealed there was no bed clip alarm utilized for Resident #5. An interview with CNA #5, on 02/17/11 at 1:55 PM, revealed she was unable to locate the resident's bed clip alarm. She stated the resident should have a clip alarm while in bed. An interview with Licensed Practical Nurse Unit Manager, on 02/18/11 at 3:05 PM, and Registered Nurse #3, on 02/18/11 at 3:15 PM, revealed they were aware the resident required a bed clip alarm and without the alarm, the resident would self-transfer and would be at an increased risk for falls. An interview with the Director of Nursing, on 02/18/11 at 3:25 PM, revealed she expected the clip alarm to be in place as directed by the physician's order. The lack of the clip alarm placed the resident at risk for attempted episodes of self-transfer without staff's knowledge.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185382	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 02/17/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.